End-Stage Renal Disease Network Program

Treatment Modalities: Transplant and Home Best Practice Webinar

February 7, 2023

Today's Agenda

Meeting Reminders

Facility Report Cards

Guest Speaker 1

Home Interventions

Guest Speaker 2

Closing Remarks

Meeting Reminders

- Please mute your line when not speaking to avoid background noise
- Be present and engaged
- Participants are encouraged to utilize chat to ask questions and make comments using “to everyone”
- All meeting materials will be available via IPRO Learn

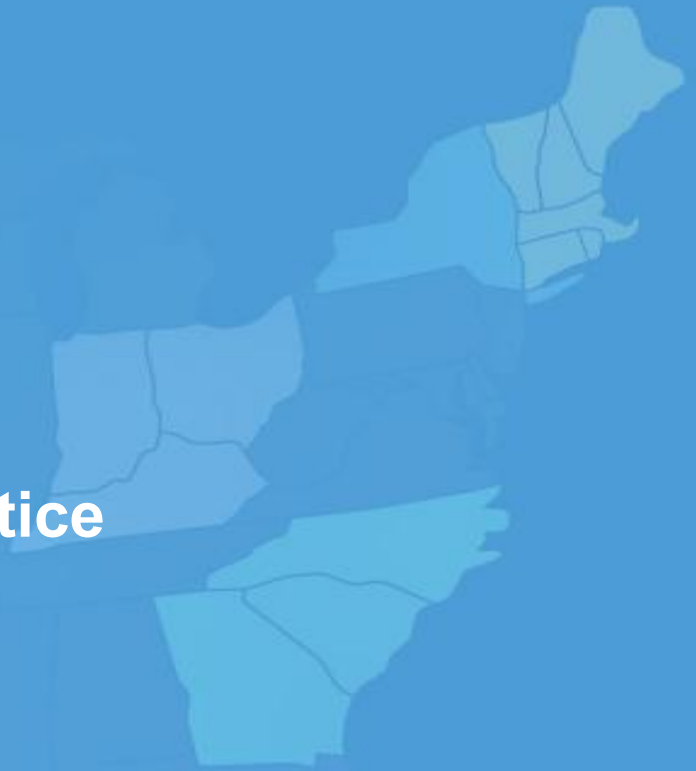
Objectives

At the completion of this call, the attendee will be able to:

- Understand the current treatment modality report cards
- Identify at least one best practice in the area of transplant and home modality to implement at their facility
- Understand the depth of a pro-transplant culture at a facility and how it can affect success
- Understand the benefit of expanding education on early home starts in CKD and preemptive waitlist and transplant

Facility Report Cards:
A Waitlist and Transplant Best Practice

Caroline Sanner, MSN, RN-BC, CPHQ
Quality Improvement Project Manager
Transplant Lead



Who Gets This Report?

- This report is sent to:

  Facility Data EQRS Contact

  Facility Head Nurse/Nurse Supervisor

  Facility Administrator

  Facility Transplant Lead

  Facility Medical Director

  Regional Quality Manager

  Facility Home Program Manager

  Facility Social Worker

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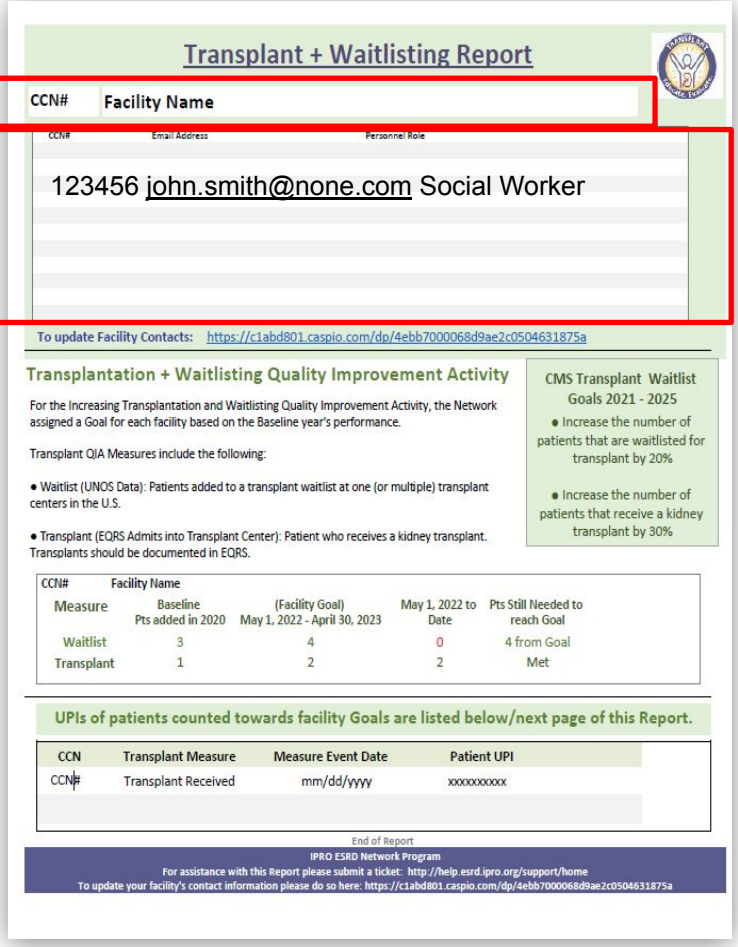

Transplant + Waitlisting Report

CCN# Facility Name

CCN#	Email Address	Personnel Role
123456	john.smith@none.com	Social Worker

To update Facility Contacts: https://c1abd801.caspio.com/dp/4ebb7000068d9ae2c0504631875a

Transplantation + Waitlisting Quality Improvement Activity

For the Increasing Transplantation and Waitlisting Quality Improvement Activity, the Network assigned a Goal for each facility based on the Baseline year's performance.

Transplant QIA Measures include the following:

- Waitlist (UNOS Data): Patients added to a transplant waitlist at one (or multiple) transplant centers in the U.S.
- Transplant (EQRS Admits into Transplant Center): Patient who receives a kidney transplant. Transplants should be documented in EQRS.

CMS Transplant Waitlist Goals 2021 - 2025

- Increase the number of patients that are waitlisted for transplant by 20%
- Increase the number of patients that receive a kidney transplant by 30%

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End of Report

IPRO ESRD Network Program

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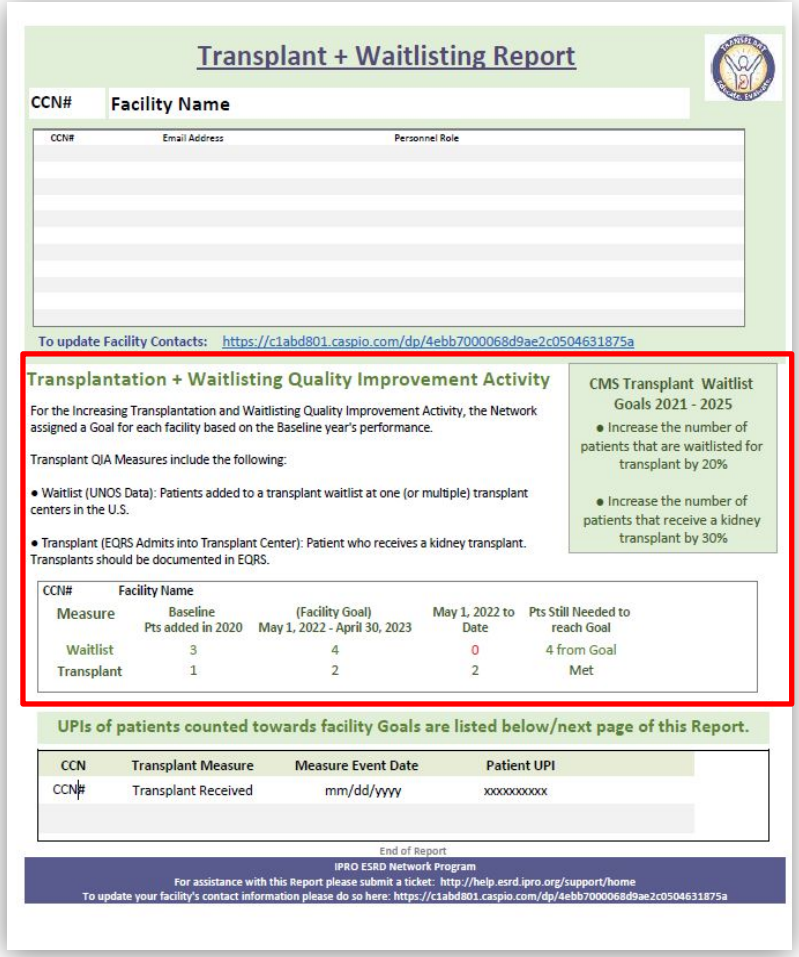
What is in the Report?

- Explains how your facilities goals are calculated and where the data comes from
- The waitlist data is directly from UNOS and it reflects **NEW waitlisted patients** from May 1, 2022 until the month before you receive the report
- The transplant data comes from EQRS Admits into the Transplant Center from May 1, 2022 until the month before you receive the report.

Example: when you receive February's report, it will be May 1, 2022 until January 2023's waitlists and transplants



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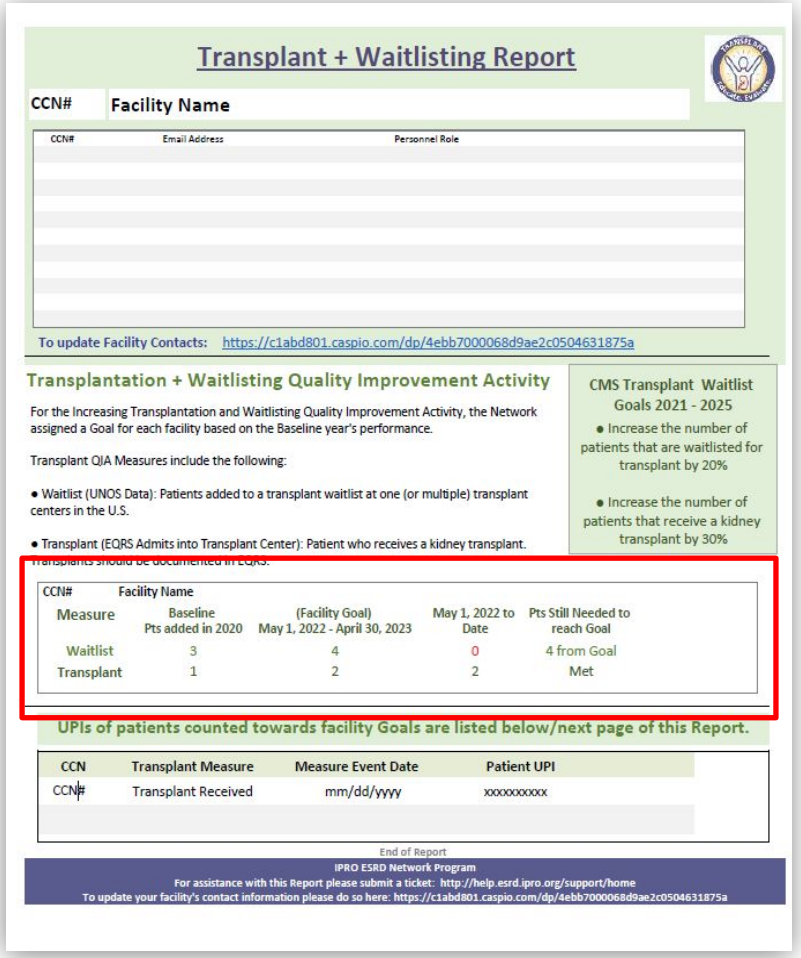
- These goals indicate what your facility should achieve to get based on your past performance (“baseline”)
- We keep track of what you have and how many more you’ll need to get so you don’t have to!
- Your facility success in these goals puts your Network in a very favorable position to meet the CMS ESRD annual goals for waitlist and transplant!
- The Network uses this data to find high and low performers!



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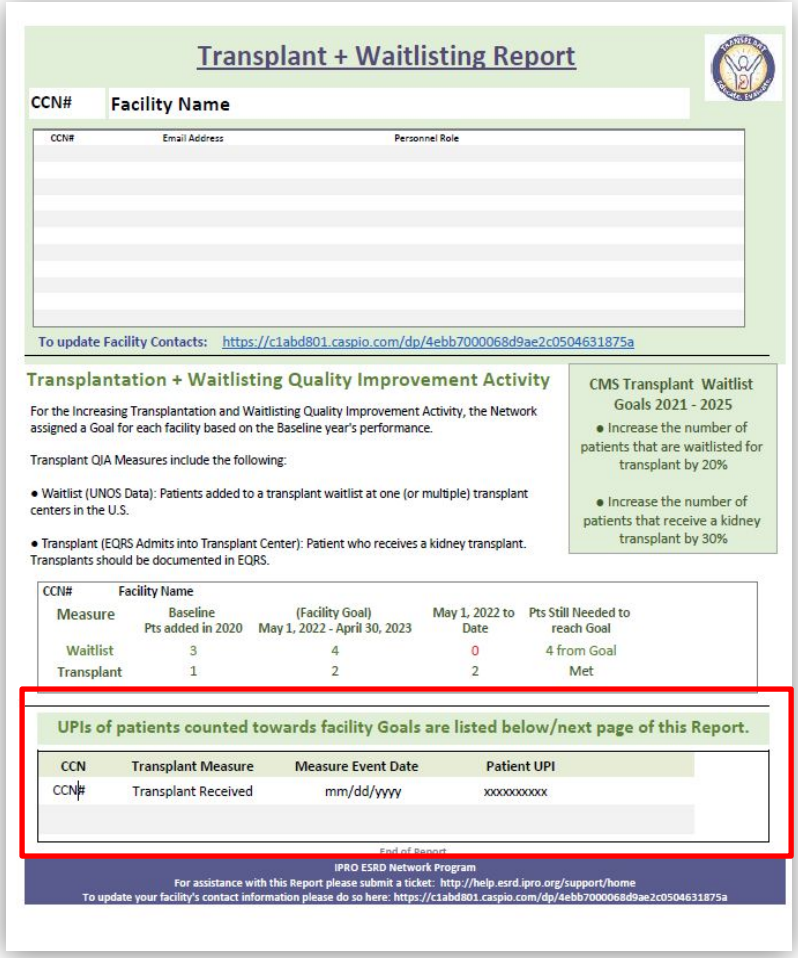
How Should I Use This?

1. Verify your records with this report, UPIs are provided for quick reference

2. Contact your transplant center for discrepancies:
   - Ensure patients were inputted into UNOs for waitlist
   - Ensure patients were admitted into EQRS for transplant

3. Share report with the IDT during QAPI meetings to discuss your facilities progress in the CMS ESRD Goals
   - If you are not meeting your goals, it's time to do a Root Cause Analysis to identify areas you can improve upon



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Best Practice Facility Demographics

U.S Renal Care Orange

- USRC
- Orange, Connecticut
- Census: 143

May 2022- December 2022	
Wait Listed	11 patients!
Transplanted	10 patients!

Best Practice Speaker: Transplant

Dawn Lawlor BSN, RN
Kidney Care Options Educator
U.S. Renal Care Orange

Agenda

- Secrets to Success
  - Organizational Culture
  - Educational Approaches
    - Health Literacy
  - Patient-Patient Support
  - Transplant Center Communication
    - Re-Referral

Secrets to Success

Organizational Culture

Kidney Care Options Educator Role

- New role at USRC, since 2020
- 20 total educators in this role, across the organization
- Patient Liaison
- Modality education for CKD Stage 4 and 5 patients
    - Encourage preemptive waitlisting and preemptive transplant

Best Practice Takeaway: A common community barrier is patients are overwhelmed when starting dialysis. Early education in CKD is more beneficial for transplant interest and getting them to complete waitlist requirements of even get transplanted before dialysis is the best option

Secrets to Success
Organizational Culture

Kidney Care Options Educator Role

- Modality education to all new ICHD patients
- Works with home and ICHD patients at Orange to refer and support throughout transplant journey
- **Designated person to follow transplant candidates**

Best Practice Takeaway: Have a Transplant Liaison to take on this responsibility to getting the patient to and through the transplant process.

Secrets to Success
Organizational Culture

“We all have the same philosophy about how we want the patients to feel when coming to dialysis. A team that is working together with a real patient focus, that’s where the patients get the best care”

Educational Approaches

Health Literacy

Best Practice Takeaways:

1. Break the ideas and discussions up into chunks
2. Talk to everyone in the simplest way possible, regardless of who the patient is or what their background is. Everyone wants and needs simplified information when it comes to their care.

Referral to Transplant
Best Practices

- Communication and rapport with the center is first step to successfully referring a patient to a transplant center
- Let the transplant center decide on eligibility!
    - They can look at the total picture of the patient and make decisions on how to assist patient achieve their transplant goals
    - Takes the personal nature out of it

        “The transplant center denied them” vs. “The facility or staff member wouldnt let them” become transplanted

Re-Referral to Transplant
Communication

There are many reasons for a patient to stop in the referral to waitlist process, health literacy was the example discussed today

- Step 1: work with the patient to address the issues
- Step 2: Before re-referring you need to open lines of communication with your transplant center
    - Understand that EHRs and records exist. You do not want past behavior or missed appointments to affect your patients current efforts at transplant
    - Need to mend the relationship, be transparent about the events that lead up to this moment and discuss you and your patients plan to be successful this time

Secrets to Success
Patient to Patient Support

- Use of transplant advocates
    - Former patients who have volunteered as mentors
    - Partner up based on similarities and experiences
    - We use mostly phone call interaction but have held lobby days/ advocacy days 2x a year
        - Former transplant recipient will sit in lobby and patients can talk to them and is usually very natural

They discuss good and bad, what it's like to be on medication, real-life occurrences, and even being on dialysis post-transplant for a period of time, help answer questions like “will I really feel better afterward”

Best Practices
U.S Renal Care Orange

- Transplant liaisons are key!
- Success in CKD Education! – preemptive waitlist and preemptive transplant
- Identify your barriers and make it your mission to overcome them
- Communicate early and often and re-refer patients with the help of the transplant centers
- Patient to patient advocacy!

Questions? Comments?

Home Modality & Telemedicine Report Cards and Home Certification Letters

Michelle Prager MSW, LSW
Quality Improvement Home Lead

Home Report Cards

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  Facility Head Nurse/Nurse Supervisor

  Facility Administrator

  Facility Transplant Lead

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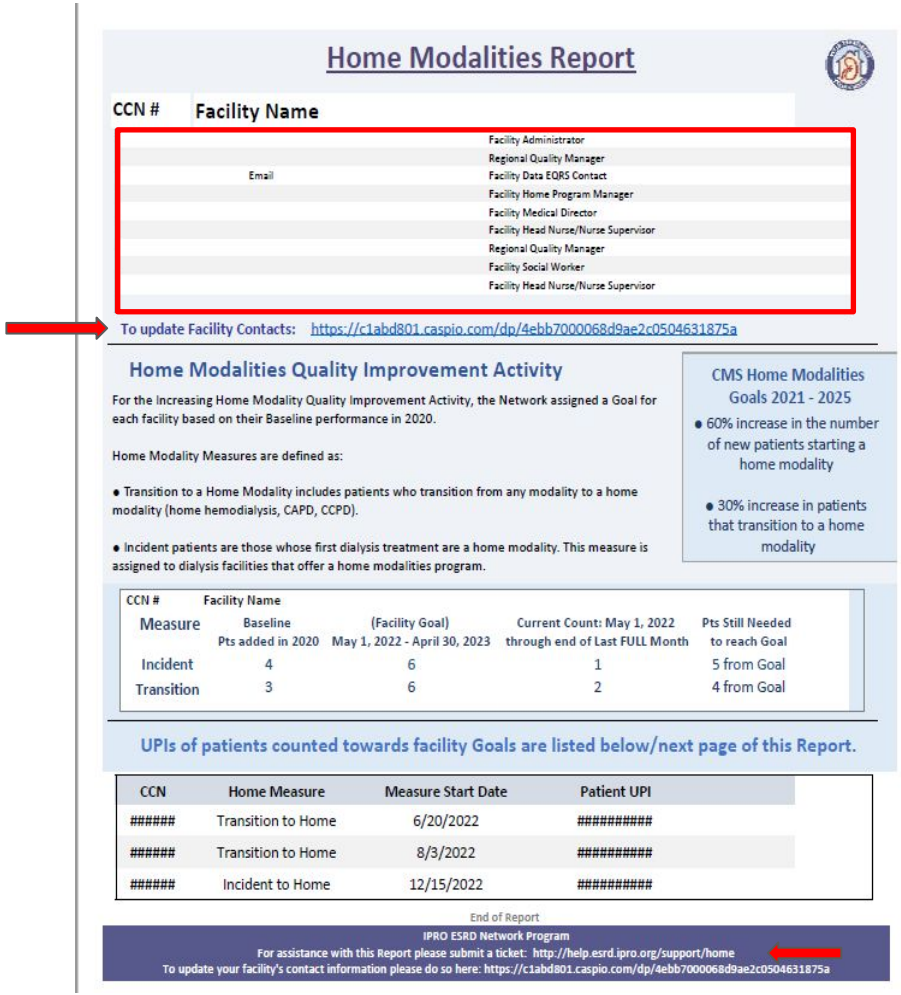

Home Modalities Report

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- 60% increase in the number of new patients starting a home modality
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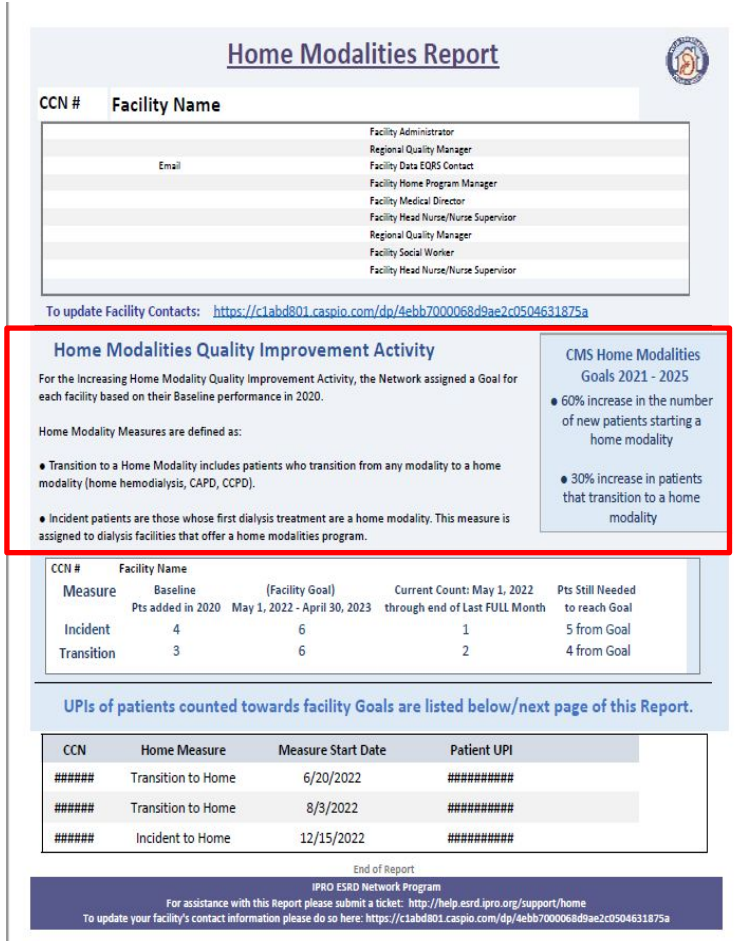
What's in the Report?

- The goals for home including Incident and Transitions
- Goals for this year are based on performance of 2020



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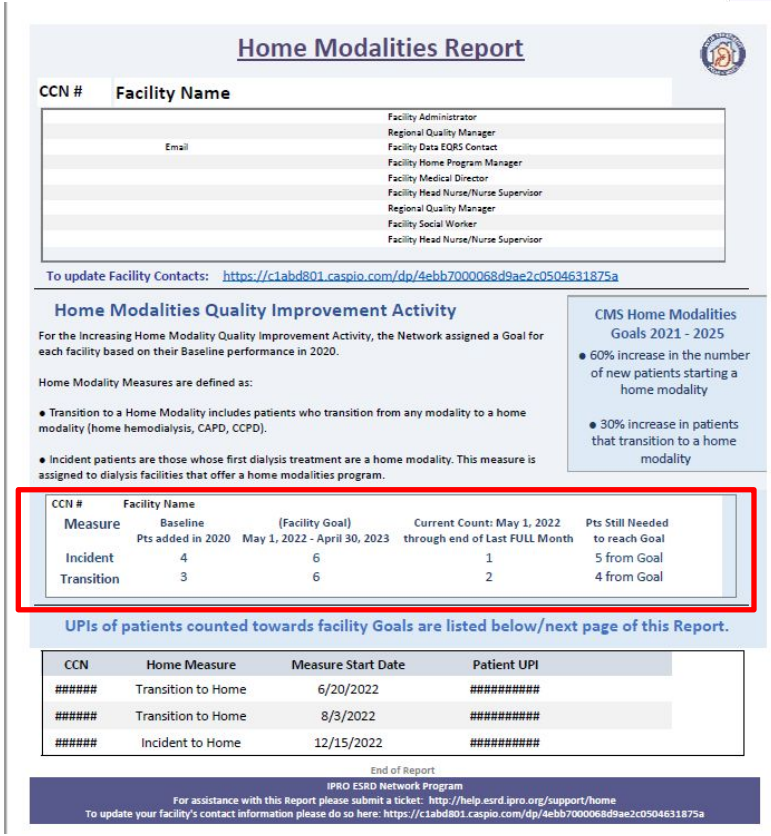

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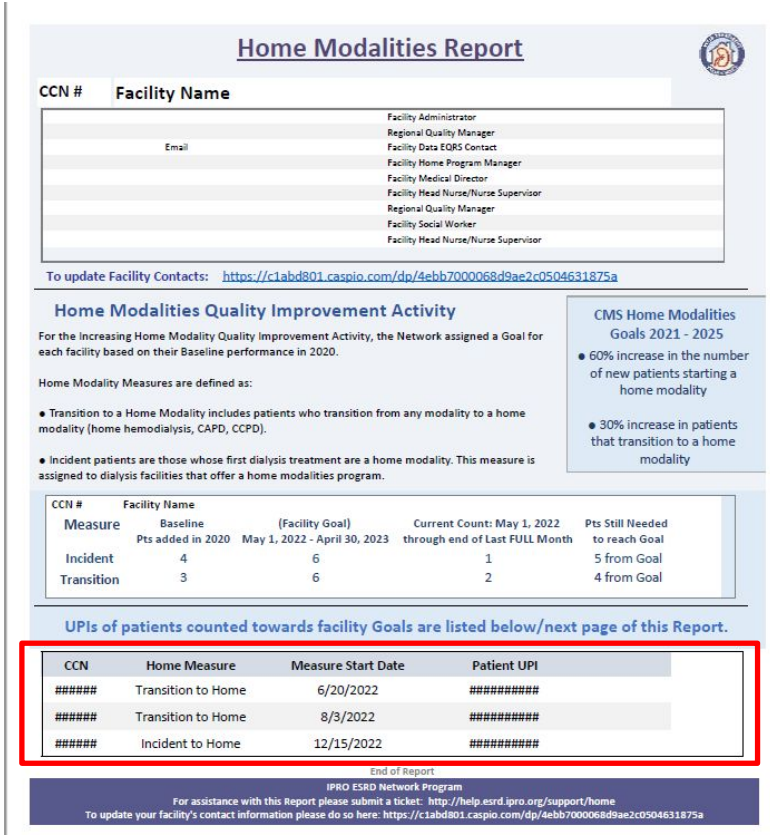
What Do I DO With This Section?

- Review your data with this section to make sure that what is in EQRS is correct
- Discuss the report card in your IDT and QAPI meetings to review progress.
- If you are not meeting your goals, complete an RCA and an action plan with areas to work on.



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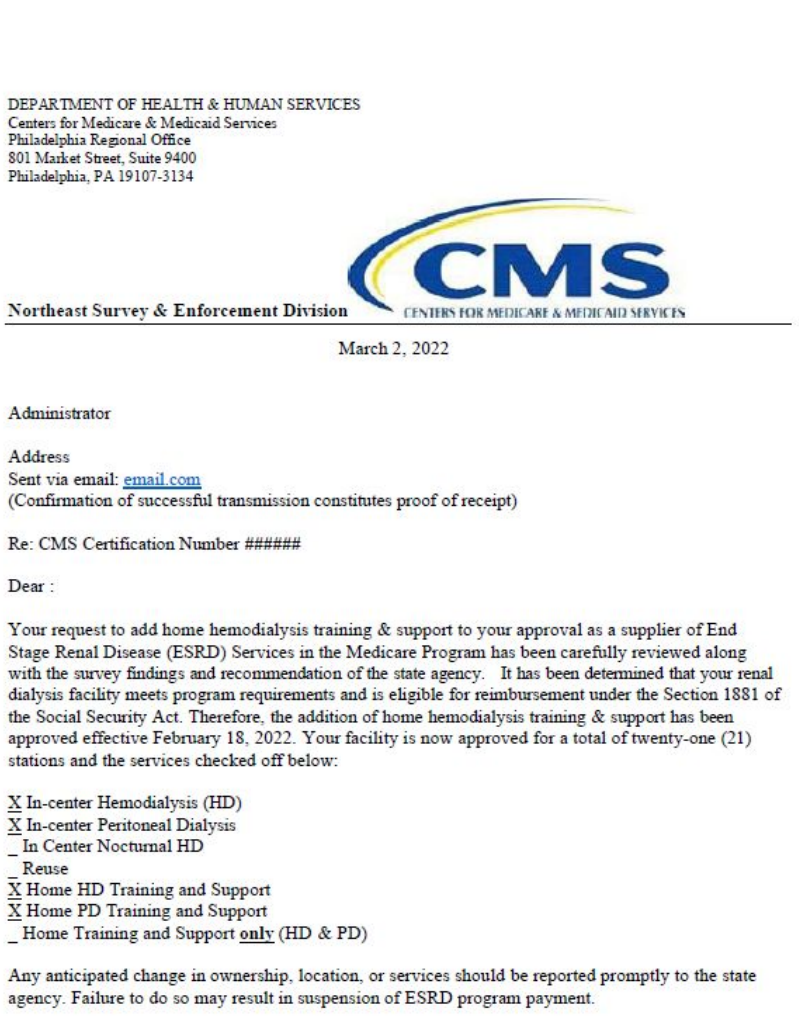
Certification Letters

- Certification letter showing in-center and home stations
- Share this certification letter with the Network and keep in a binder at your facility



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
801 Market Street, Suite 9400
Philadelphia, PA 19107-3134

Northeast Survey & Enforcement Division

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

March 2, 2022

Administrator

Address
Sent via email: email.com
(Confirmation of successful transmission constitutes proof of receipt)

Re: CMS Certification Number ######

Dear :

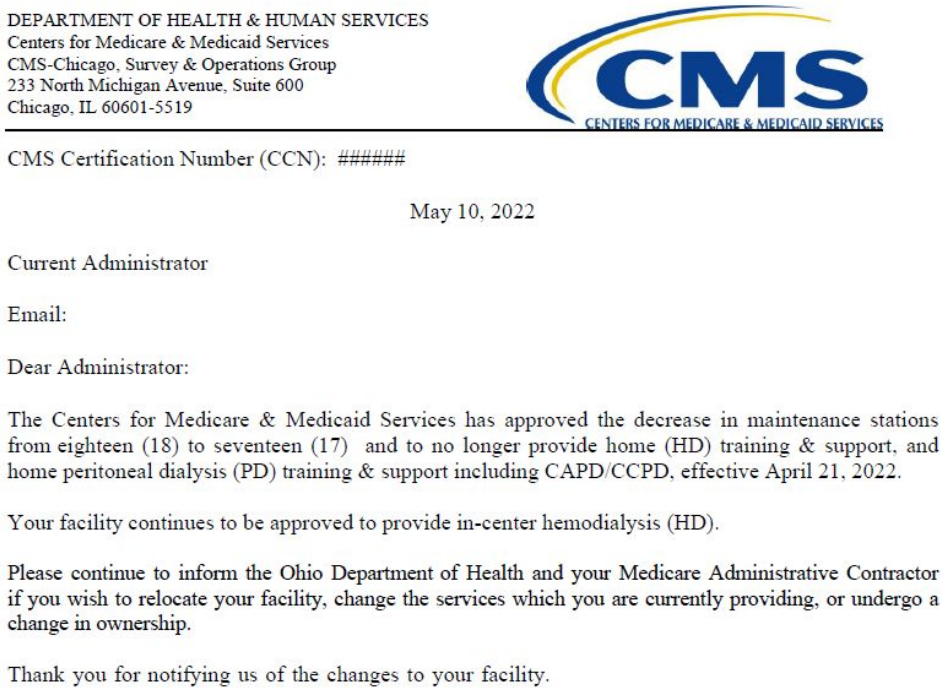
Your request to add home hemodialysis training & support to your approval as a supplier of End Stage Renal Disease (ESRD) Services in the Medicare Program has been carefully reviewed along with the survey findings and recommendation of the state agency. It has been determined that your renal dialysis facility meets program requirements and is eligible for reimbursement under the Section 1881 of the Social Security Act. Therefore, the addition of home hemodialysis training & support has been approved effective February 18, 2022. Your facility is now approved for a total of twenty-one (21) stations and the services checked off below:

X In-center Hemodialysis (HD)
X In-center Peritoneal Dialysis
_ In Center Nocturnal HD
_ Reuse
X Home HD Training and Support
X Home PD Training and Support
_ Home Training and Support **only** (HD & PD)

Any anticipated change in ownership, location, or services should be reported promptly to the state agency. Failure to do so may result in suspension of ESRD program payment.

No Longer Certified for Home

- Example of a letter that is no longer providing home dialysis
- Please make sure you share this letter with the Network as it affects your goals for home modalities



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS-Chicago, Survey & Operations Group
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Certification Number (CCN): ######

May 10, 2022

Current Administrator

Email:

Dear Administrator:

The Centers for Medicare & Medicaid Services has approved the decrease in maintenance stations from eighteen (18) to seventeen (17) and to no longer provide home (HD) training & support, and home peritoneal dialysis (PD) training & support including CAPD/CCPD, effective April 21, 2022.

Your facility continues to be approved to provide in-center hemodialysis (HD).

Please continue to inform the Ohio Department of Health and your Medicare Administrative Contractor if you wish to relocate your facility, change the services which you are currently providing, or undergo a change in ownership.

Thank you for notifying us of the changes to your facility.

Telemedicine Report Cards

- This report is sent to:

  Facility Data EQRS Contact

  Facility Head Nurse/Nurse Supervisor

  Facility Administrator

  Facility Transplant Lead

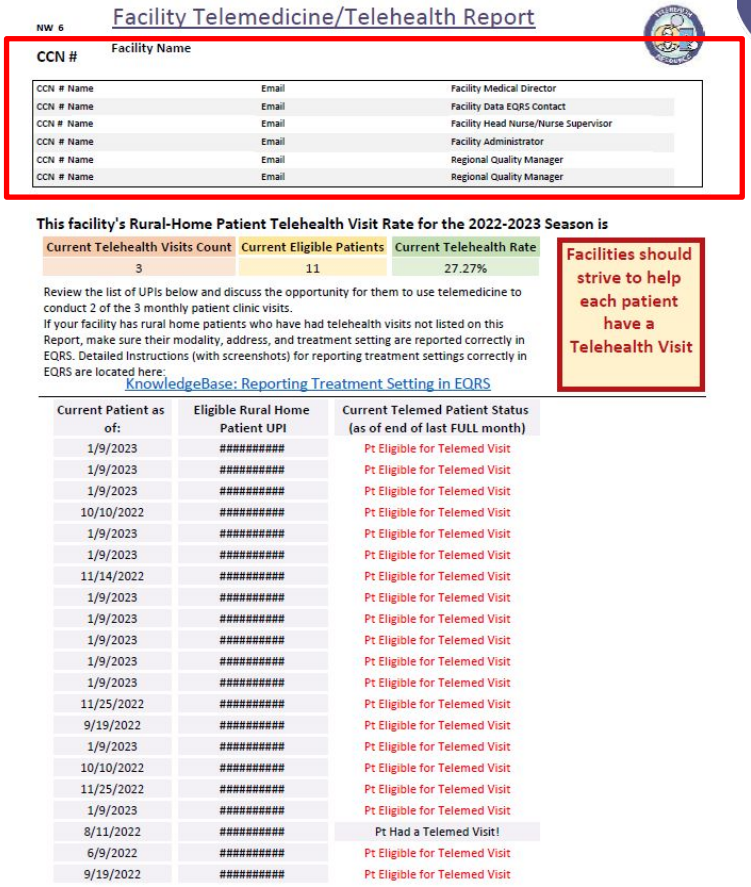
  Facility Medical Director

  Regional Quality Manager

  Facility Home Program Manager

  Facility Social Worker

- If you don't receive these, you'll need to update your facility contact information. Ensure there are no typos!



NW 6

Facility Telemedicine/Telehealth Report

CCN #

Facility Name

CCN # Name	Email	Facility Medical Director
CCN # Name	Email	Facility Data EQRS Contact
CCN # Name	Email	Facility Head Nurse/Nurse Supervisor
CCN # Name	Email	Facility Administrator
CCN # Name	Email	Regional Quality Manager
CCN # Name	Email	Regional Quality Manager

This facility's Rural-Home Patient Telehealth Visit Rate for the 2022-2023 Season is

Current Telehealth Visits Count	Current Eligible Patients	Current Telehealth Rate
3	11	27.27%

Facilities should strive to help each patient have a Telehealth Visit

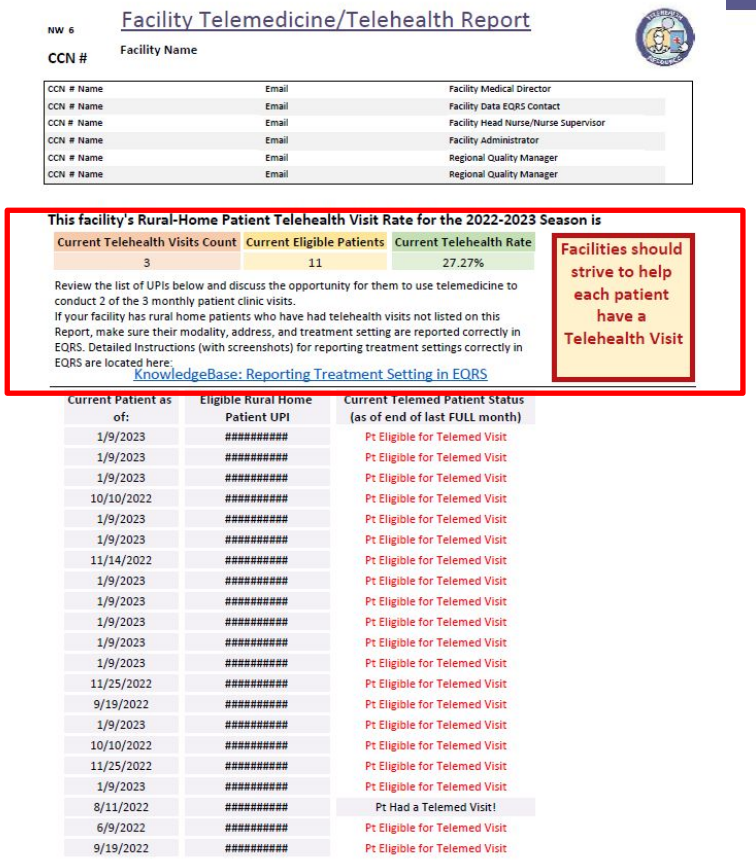
Review the list of UPIs below and discuss the opportunity for them to use telemedicine to conduct 2 of the 3 monthly patient clinic visits.
If your facility has rural home patients who have had telehealth visits not listed on this Report, make sure their modality, address, and treatment setting are reported correctly in EQRS. Detailed Instructions (with screenshots) for reporting treatment settings correctly in EQRS are located here:

KnowledgeBase: Reporting Treatment Setting in EQRS

Current Patient as of:	Eligible Rural Home Patient UPI	Current Telemed Patient Status (as of end of last FULL month)
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
10/10/2022	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
11/14/2022	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
11/25/2022	##########	Pt Eligible for Telemed Visit
9/19/2022	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
10/10/2022	##########	Pt Eligible for Telemed Visit
11/25/2022	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
8/11/2022	##########	Pt Had a Telemed Visit!
6/9/2022	##########	Pt Eligible for Telemed Visit
9/19/2022	##########	Pt Eligible for Telemed Visit

Telehealth Visit Rate

- This section reviews current visits, current eligible patients and current telehealth rate
- Review the UPI's below to discuss opportunity for telemed visits
- Use the Knowledge Base: Reporting Treatment Setting in EQRS job aid if needed



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1/9/2023	##########	Pt Eligible for Telemed Visit
11/14/2022	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
1/9/2023	##########	Pt Eligible for Telemed Visit
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6/9/2022	##########	Pt Eligible for Telemed Visit
9/19/2022	##########	Pt Eligible for Telemed Visit

Updating Patient Treatment Setting in EQRS

Identify when and where each patient receives his/her dialysis treatment.

When did they actually start dialysis? Do they travel into the community for dialysis treatment? Do they get bedside peritoneal dialysis or "home dialysis" (frequent hemodialysis treatments)?

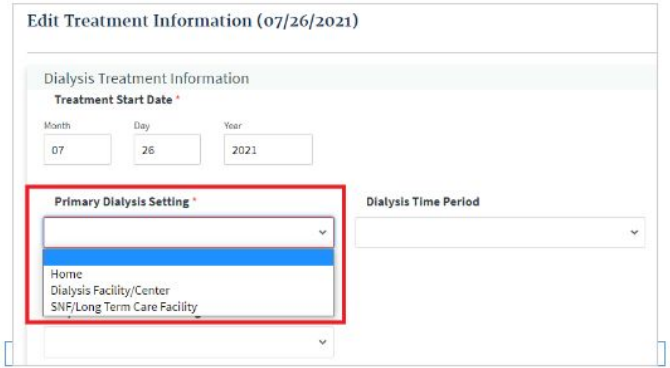
Follow the screenshots below to make all necessary entries in EQRS to each patient's record.

Perform this EQRS patient contact information data review each month.

- Log in to EQRS https://eqrs.cms.gov/
- From the Dashboard select **Patients** (top banner)
- **Search** for the patient
- Go to **Treatments**
- Click on the most current **Admit Date** for your facility
- Go to **Treatment Summary** (bottom)
- Click on the most current **Treatment Start Date**
- Click on **EDIT** or add **New Treatment** if needed
    - Do not change historic treatment data unless it is incorrect
    - Use **New Treatment** button to enter new data whenever patient changes modalities

- Verify that the **Treatment Start Date** is correct

- Verify that the **Primary Dialysis Setting** is correct
    - **Home:** Patient receive hemodialysis or peritoneal (PD) treatment in their residence as defined by their permanent address.
    - **Dialysis Facility/Center:** Patient travels to outpatient dialysis facility 3x per week to receive treatment.
    - **SNF/Long Term Care Facility:** Patient is receiving this dialysis treatment in a Skilled Nursing Facility (short term) within a Long Term Care Facility. This may or may not be the patient's permanent address.

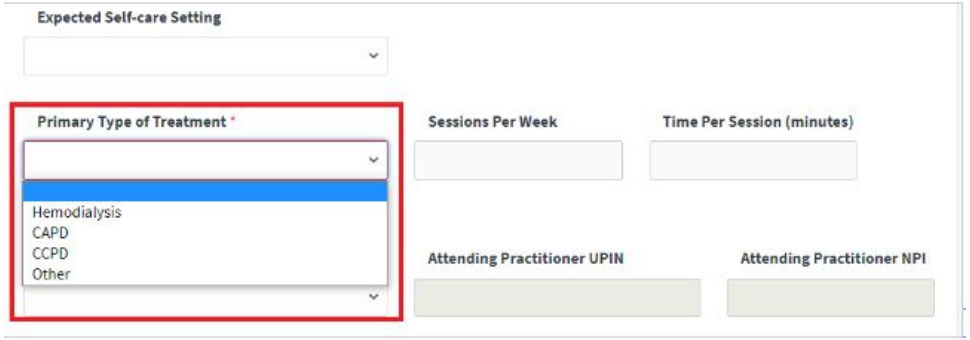


- Verify **Dialysis Time Period**
    - **Nocturnal:** Slow, longer hemodialysis treatment that takes place at night while you sleep.
    - **Daytime:** Dialysis while patient is awake.

- Verify the **Primary Type of Treatment**
    - **Hemodialysis (**include **Sessions Per Week** and **Time Per Sessions (minutes))**
    - **CAPD**
    - **CCPD**

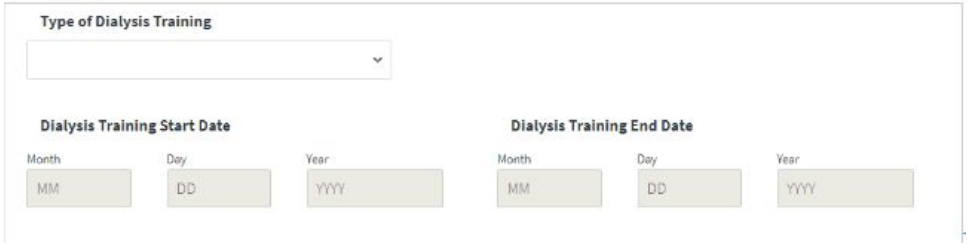
Updating Patient Treatment Setting in EQRS Continued

- Verify **Attending Practitioner** information



- Verify **Type of Dialysis Training** information ONLY IF patient TRAINED for this Treatment modality
  - **Hemodialysis:** only if patient trained for home dialysis
  - **CAPD:** usually requires Training if CAPD is patient's NEW home modality
  - **CCPD:** usually requires Training if CCPD is patient's NEW home modality

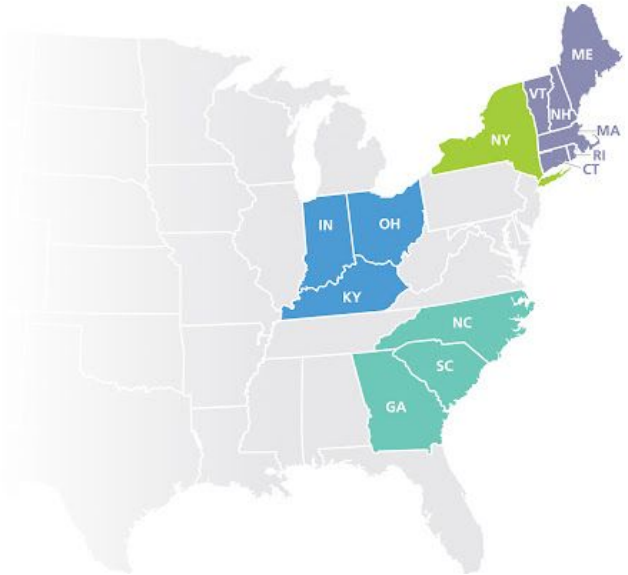
- **Dialysis Training Start Date** and **Dialysis Training End Date** should be populated IF patient TRAINED



Best Practice Facility

FMC Dayton Regional Dialysis - North

- According to December data, **# 5** across all 4 NETWORKS IPRO covers for Incident patients
- 28 Incident patients to date (December)
- 11 transitions to date (December)



Home Modality Best Practice Speaker

Traci Greene, RN
Home Therapies Market Manager Greater Dayton
Fresenius Dayton North


IPRO Community
Advisory Panel

Fresenius Dayton North Demographics

- In-center census: 88
- Peritoneal Dialysis: 58
- Home Hemodialysis: 29

Home First

- CKD Education prior to starting
- Peritoneal Dialysis Urgent Start
- Home is the first modality

Educating Patients about Home

- Physician Champions Home
- Patient advocates to talk with patients about home
- Training in-center staff to educate on home
- CM educates in-center patients
- Every treatment is modality education

Barriers to home: Fearful

- Certifying 8 home chairs in-center for self care
- Alexa for patients to call 911 or get help in the home
- Emergency setup on file with Fire Department for access to the house

Barriers to Home: Not Interested

- In-center is temporary
- Doing away with home visit prior to starting on home
- Don’t delay home training

Every patient gets a try

- Success story of a “non-compliant” patient

Questions? Comments?

Thank You!

Please complete the post-webinar survey!

Corporate Headquarters
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Lake Success, NY 11042-1072

http://ipro.org